Medicaid Cost Containment Strategies

MaineCare Redesign Taskforce
September 25, 2012

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Background

- Medicaid agencies around the country are experiencing significant budget constraints
  - Immediate savings have been realized through traditional strategies aimed at decreasing utilization & restricting reimbursement
    - Such strategies need to be explored in the context of long-term impact on access to care & cost shifting
  - Longer-term strategies continue to be explored to transform the delivery of care to both improve quality outcomes & realize cost savings

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Overview:
Potential Cost-Containment Strategies

- Potential short-term strategies (6-12 mos)
  - Increased cost-sharing
  - Benefit reductions & limitations
  - Rate changes

- Potential mid-term strategies (1-3 years)
  - Pharmacy targeted reforms
  - Reducing prescription drug abuse
  - Eligibility changes
  - Quality initiatives
  - Managing high cost enrollees
  - Program integrity initiatives
  - Reimbursement reforms

- Potential long-term strategies (3-5 years)
  - Value Based Purchasing
  - HIT
  - Managing duals
  - Managing long-term care and high cost populations

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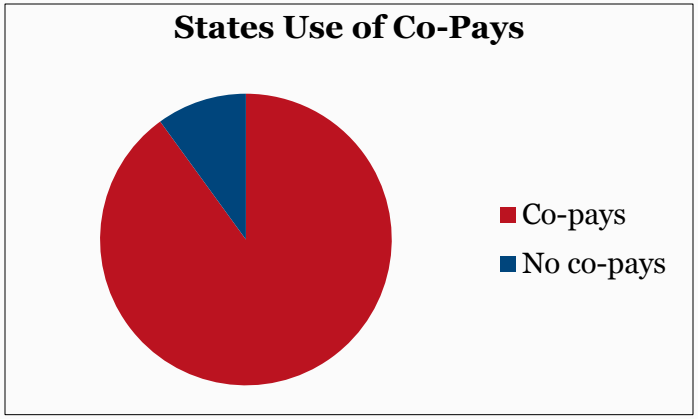
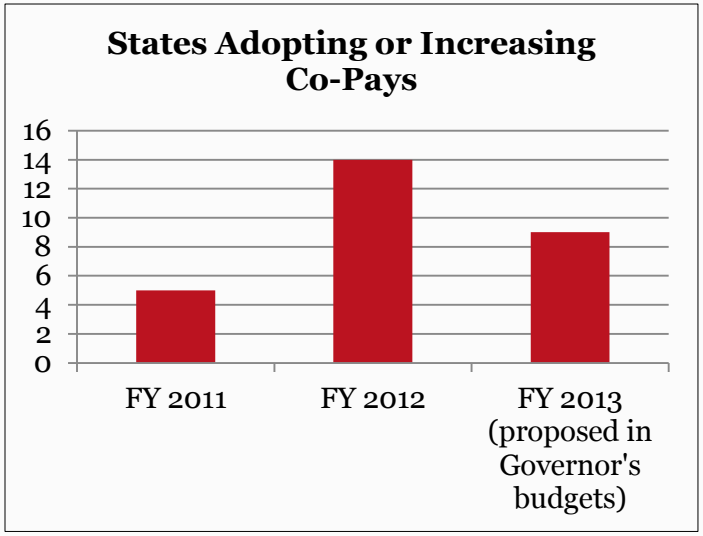
Short-Term Strategy: Cost Sharing

- Co-Pays
  - Widely used as a cost-containment strategy
  - MaineCare is not currently imposing the maximum allowable co-pays
- Premiums
  - Increases not allowable until expiration of ACA MOE
    - States that had language 3/23/10 to automatically increase premiums may do so
    - Inflation-related adjustments allowed
- Deductibles
  - MN: Implemented $2.55 deductible effective 1/1/12





Source: Kaiser Foundation, Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012, October 2011.

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Overview: Federally Allowable Co-Pays

Adults			
	≤100% FPL	>100% - ≤150% FPL	>150% FPL
Preferred Prescription Drugs	Nominal	Nominal	Nominal
Non-Preferred Prescription Drugs	Nominal	Nominal	May not exceed 20% of cost of drug
Non-Emergency use of ER	Nominal	May not exceed 2x nominal	No limit[2]
Other Services[1]	Nominal	May not exceed 10% of payment agency makes for the service	May not exceed 20% of payment agency makes for the service

[1] Co-pays may not be imposed for certain services including emergency services & family planning. Preventive services exempt as of 1/1/14.
[2] 5% aggregate cost sharing limit applies.

Children			
	≤133% FPL[1]	133% FPL - ≤150% FPL	>100% to ≤150% FPL
Preferred Prescription Drugs	Not Allowed	Not Allowed	Nominal
Non-Preferred Prescription Drugs	Nominal	Nominal	May not exceed 20% of cost of drug
Non-Emergency use of ER	Nominal	May not exceed 2x nominal	No limit[2]
Other Services[3]	Not allowed	May not exceed 10% of payment agency makes for the service	May not exceed 20% of payment agency makes for the service

[1] Applies to "mandatory" children; currently at 100% FPL for children ages 6-18. Will become 133% FPL for all children as of 1/1/14.
[2]5% aggregate cost sharing limit applies
[3]Co-pays may not be imposed for certain services including emergency services & family planning.

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MaineCare Adult Co-Pays vs. Federal Allowances

State Payment For Service	Federally Allowable Nominal Amount[1]	MaineCare Co-Pay
$10.00 or less	$0.65	$0.50
$10.01 - $25.00	$1.30	$1.00
$25.01 - $50.00	$2.55	$2.00
≥$50.01	$3.80	$3.00

[1] FY 2012 maximum nominal co-pay amounts. FY 2013 amounts to be published by CMS by October 1, 2012.

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MaineCare Child Co-Pays vs. Federal Allowances

MaineCare children are currently exempt from co-pays. The following charts outline where co-pays may be implemented for this population.[1]

Services[2]	
FPL	**Potential Change**
≤133%	N/A
>133% & ≤150%	Up to 10% of the cost of the service
>150%	Up to 20% of the cost of the service

Prescription Drugs		
FPL	**Potential Change: Preferred Drugs**	**Potential Change: Non-Preferred Drugs**
≤133%	N/A	Impose Nominal Amount
>133% & ≤150%	N/A	Impose Nominal Amount
>150% FPL	Impose Nominal Amount	Up to 20% of the Cost

Non-Emergency Use of ER	
FPL	**Potential Change**
≤133%	Impose Nominal Amount
>133% & ≤150%	Up to 2x Nominal Amount
>150%	No limit

[1] Per federal regulations, children in foster care or adoption assistance exempt from cost-sharing; Indian children receiving services from Indian health care providers also exempt.

[2] Cost-sharing prohibited for some services including emergency services, family planning & preventive services.

Potential Implications of Increased Cost Sharing

- Studies on the impact of cost-sharing on access to care, utilization & health outcomes have produced mixed results
  - Cost-sharing has been shown in some studies to reduce utilization especially for primary care & preventive services
  - Medicaid savings are not always realized as care may shift to higher cost hospital services
- Shift of burden to providers who may experience reduced reimbursement when enrollees fail to pay

Source: Kaiser Foundation, Health Insurance Premiums & Cost-Sharing: Findings From Research on Low-Income Populations, March 2003

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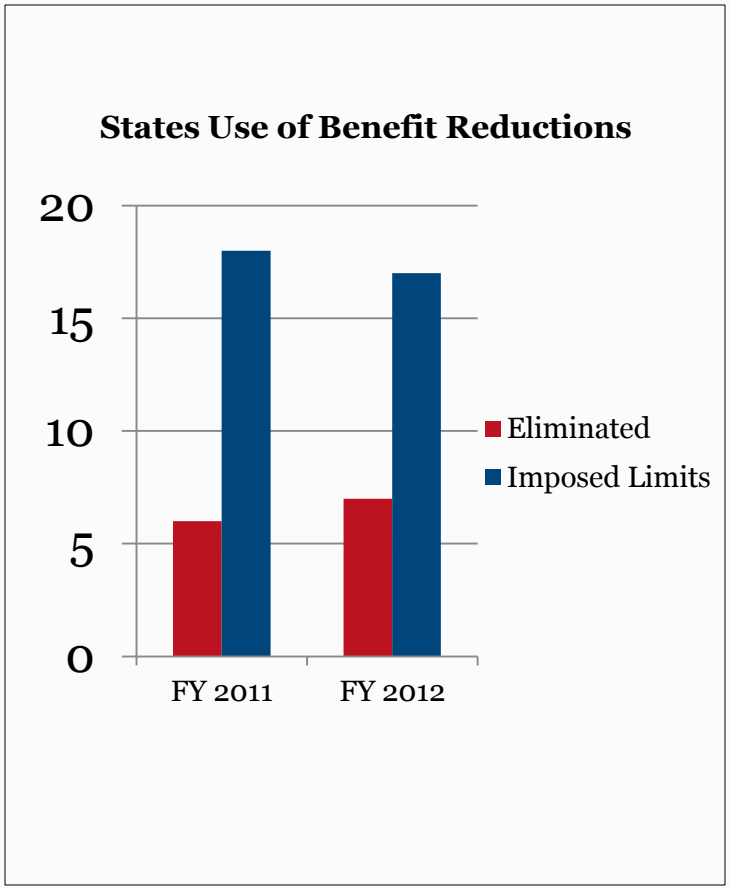
Short-Term Strategy: Benefit Reductions

- Benefit changes have been a common cost-containment strategy
- Common benefits targeted for reduction include:
  - Home health & personal care
  - Dental
  - Physical, Speech & Occupational Therapy
  - Vision*



* Maine recently implemented a 1 visit/3 year limit vs. previous 1 visit/2 years.

Source: Kaiser Foundation, Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012, October 2011.

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Mandatory Medicaid Benefits

Mandatory Medicaid Benefits - Not Eligible for Elimination Limits May Be Imposed
• Inpatient hospital • Outpatient hospital • Early & Periodic Screening, Diagnostic & Treatment Services (EPSDT) • Nursing facility • Home health • Physician services • Rural health clinic services • FQHC services • Lab & x-ray • Family planning • Nurse midwife • Certified Pediatric & Family Nurse Practitioner services • Freestanding Birth Center services (when recognized by State) • Transportation to medical care • Tobacco cessation counseling for pregnant women

Source: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html

Optional Medicaid Benefits

Eligible for Elimination or Reduction

- Prescription drugs
- Clinic services
- Physical therapy*
- Occupational therapy*
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive & rehabilitative services
- Podiatry services
- Optometry services
- Dental services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services*
- Other practitioner services
- Private duty nursing services
- Personal care
- Hospice
- Case management*
- Services for individuals 65 and older in an Institution for Mental Disease
- Services in an intermediate care facility for the mentally retarded
- State plan home & community based services * -1915(i)
- Self-directed personal assistance services – 1915(j)
- Community first choice option - 1915(k)
- TB related services
- Inpatient psychiatric services for individuals under 21

Source: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html

* Maine has made changes to these services.

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Benefit Reductions: A Sampling of FY 2011 State Initiatives

State	Benefit Reductions
AZ	• Most dental • Podiatry • Percussive vests • Hearing Aids • Cochlear Implants • Orthotics
ID	• Collateral contact & DD supportive counseling
MA	• Restorative dental & dentures
SC	• Podiatry • Vision • Dental
NC	• Obesity surgery • Maternal outreach worker program • Panniculectomy procedures

Source: Kaiser Foundation, Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012, October 2011.

Benefit Reductions: A Sampling of FY 2012 State Initiatives

State	Benefit Reductions
CA	• Adult day health
CO	• Circumcision • Oral hygiene instruction
ID	• Eyeglasses • Audiology
NC	• Eye exams • Optical supplies
WA	• Eyeglasses • Hearing aids & devices
IN	• Targeted case management

Source: Kaiser Foundation, Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012, October 2011.

Benefit Limitations: A Sampling of State Initiatives

States	Service Category – Benefit Limitations Imposed (FY 2011-12)
MN, ID	Chiropractic
AZ, IN, MA, NJ, NM, SC, WA, CO, CT, ID, IA, NC, PA, WA	Dental or dentures
SC, CO, NC	Home health
VT, CO, OR	Imaging services
IN, MA, HI, OR	Inpatient hospital stays
AZ, CO, NH, OR, WA	Outpatient hospital/ER
ID, IN, HI, ID	Mental health
AZ, IN, VT, VA, CO, ID, NY, NC, OR, WA	Occupational, physical or speech therapy
DC, NM, NC, WA, HI, MI, NY, NC	Personal care services
NH, ID, WA	Podiatry
CT, ID, IN	Vision services

Source: Kaiser Foundation, Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012, October 2011.

A Snapshot of MaineCare Optional Benefits vs. Other States

Benefit	Maine's Policy	# States Not Covering	Examples of More Restrictive State Policies
Optometry services	Eye Exams: • Under 21 : 1/yr • 21 & over: 1 every 3 rolling CY unless indicated as standard of care for specific dx (eg. diabetes) or medication use Eyeglasses: • Under 21: When the refractive error meets specified parameter • Adults:1 pair per lifetime when power equal or greater than 10.00 diopters	0- optometry 6- eyeglasses	• AZ: limited to emergency eye care & treatment of medical conditions; vision exams limited to post cataract surgery • CO: limited to services to dx or treat injury or disease of eye, or after eye surgery • Delaware: Routine not covered • FL: Limited to determining presence of disease or reported vision problem • KS: 1 refractive exam/4 years • MI: Routine vision not covered • MS: 1 refractive exam/5 years

Maine's policies retrieved from http://www.maine.gov/sos/cec/rules/10/ch101.htm
Other State's policies effective October 2010; retrieved from Kaiser Family Health Foundation Medicaid Benefits: Online Database.

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A Snapshot of MaineCare Optional Benefits vs. Other States

Benefit	Maine's Policy	# States Not Covering	Examples of More Restrictive State Policies
Chiropractic services	• Limited to 12 visits/yr • Limited to acute conditions • Rehab potential must be documented	25	CA: limited to pregnant or institutionalized adults NC: 8 visits/yr OR: services limited to funded conditions on priority list UT: Adult coverage limited to pregnant women VT: 10 visits/yr
Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)	• 10 hospital leave days/yr • 36 therapeutic days/yr	7	Other states have more restrictive hospital leave & therapeutic leave days: Examples: • 10 states hospital leave days not covered • 3 states with lower hospital leave stays (as low as 3) • Multiple states with lower therapeutic leave stays (22)
Services in an intermediate care facility for the mentally retarded	• 25 hospital leave days/yr • 52 therapeutic leave days/yr	3	Other states have more restrictive hospital leave & therapeutic leave days: Examples: • 9 states hospital leave days not covered • 25 with lower hospital leave days (ranging from 3 days to 18) • Multiple states with lower therapeutic leave days (as low as 5 days/yr)

Maine's policies retrieved from http://www.maine.gov/sos/cec/rules/10/ch101.htm
Other State's policies effective October 2010; retrieved from Kaiser Family Health Foundation Medicaid Benefits: Online Database.

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Benefit Reduction Considerations

- Early, Periodic, Screening, Diagnostic & Treatment
- EPSDT is mandatory for children
  - States must provide all medically necessary services to treat a condition identified during the screening
- Need to ensure reductions do not shift care to more expensive settings & services
  - Example: shift from primary care to ER
- CMS approval required through SPA process
- Federal requirement to provide services that are sufficient in "amount, duration & scope to reasonably achieve their purpose"

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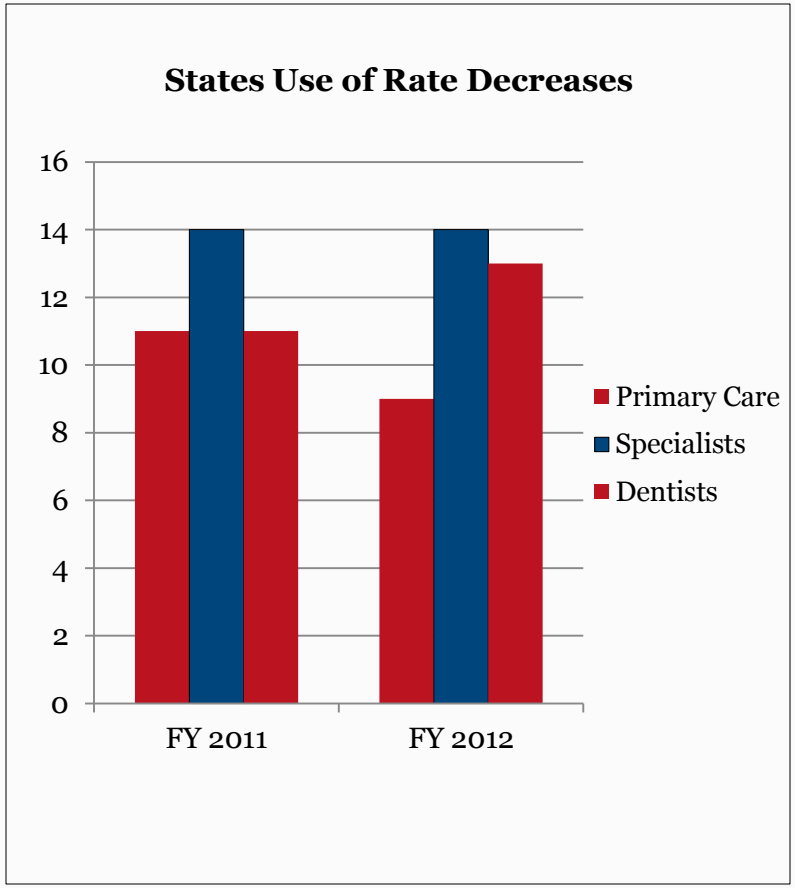
Short-Term Strategy: Rate Changes

- Rate reductions have been the most common cost-containment strategy among States
- The ACA MOE does not prohibit rate reductions
- The most common categories of providers subject to reductions among states:
  - Medical equipment
  - Medical supplies
  - Ambulance
  - Home health
  - Mental health
  - Outpatient hospital
  - Chiropractor
  - Non-emergency transportation
  - HCBS
  - Podiatry
  - C-Section



Source: Kaiser Foundation, Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012, October 2011.

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Potential Implications of Rate Changes

Pros	Cons
• Immediate savings • Analysis may reveal payments are actually inflated for certain provider types ▫ Ex: In Maryland, add-ons had been paid to healthcare providers managing communicable diseases. Costs found not to justify the add-on.	• Providers may leave the market • The impact on providers increases over the years as costs rise and reimbursement does not • Access to care concerns • Need to ensure the State upholds its obligation under the "Equal Access Provision"

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Mid-Term Strategy: Pharmacy Targeted Reforms

- General pharmacy cost-savings strategies have centered around:
  - Employing PDLs & prior authorization*
  - Supplemental rebate programs*
  - Changes to ingredient cost-reimbursement
  - Increased use of generics*
  - Increased use of mail-order prescriptions
  - Enhanced management for high cost & overprescribed drugs
  - HIT to encourage appropriate prescribing patterns
  - Cost sharing incentives
  - 340b payment at cost

* Maine currently employs these methods

Source: Kaiser Family Foundation, Managing Medicaid Pharmacy Benefits: Current Issues & Options, September 2011

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Mid-Term Strategy: Pharmacy - Specialty Drugs

- Spending on Specialty Drugs represents a critical component of State cost-containment strategies due to rapidly increasing expenses
  - 2010: 19.6% increase[1]
  - Projected to increase by over 25% annually[1]
- State approaches:
  - Contracting with Specialty Drug Vendors
  - Setting Maximum Allowable Cost rates
  - Deeper discounts on specialty drugs
  - Evaluating ingredient cost & dispensing fee reimbursement
    - Some states have instituted differential reimbursement for specialty medications; instituting more aggressive discounts

[1]Express Scripts 2010 Drug Trend Report.
Kaiser Family Foundation, Managing Medicaid Pharmacy Benefits: Current Issues & Options, September 2011. United Hospital Fund, Medicaid Prescription Drugs: Purchasing & Management, 2011.

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Mid-Term Strategy: Pharmacy - Ingredient Cost Reimbursement

- Average Acquisition Cost (AAC) payment methodology
  - Replaces Average Wholesale Price (AWP) or Wholesale Acquisition Cost (WAC) methodology which are not based on actual sales transactions
  - Uses invoices of pharmacy purchases from drug manufacturers & wholesalers
  - CMS developing pricing file to be available to States

States Implementing AAC

State	Projected Savings
AL	6% Net
OR	$1.6M Annual
IA	Planned
LA	Planned

Source: Kaiser Family Foundation, Managing Medicaid Pharmacy Benefits: Current Issues & Options, September 2011

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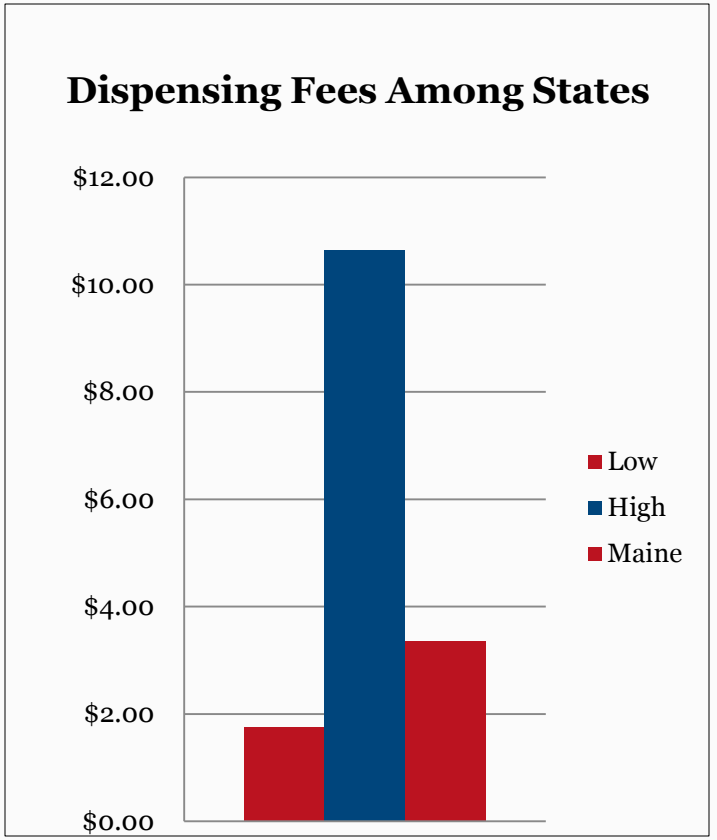
Potential Implications of AAC Payments

- Individual State analysis critical
- Some States found AAC methodology would cost them more due to increased dispensing fee typically accompanying change
- State Plan Amendment (SPA) required

Source: Kaiser Family Foundation, Managing Medicaid Pharmacy Benefits: Current Issues & Options, September 2011

Mid-Term Strategy: Pharmacy - Dispensing Fee Reimbursement

- Evaluating dispensing fees in conjunction with ingredient costs represents a potential area for State savings
- While pharmacies complain Medicaid dispensing fees do not cover their costs, the average commercial payment for retail brand prescriptions has often been below Medicaid reimbursement



March 2011 Data: Only includes data on States who like Maine do not have variable or tiered reimbursement

Source: Kaiser Family Foundation, Managing Medicaid Pharmacy Benefits: Current Issues & Options, September 2011

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Mid-Term Strategy: Pharmacy – Reducing Prescription Drug Abuse

Studies have estimated total cost to US of nonmedical use of prescription drugs at $53.4B

State Strategies for Reducing Prescription Drug Abuse

Prescription Drug Monitoring Programs	• Evaluate Maine's current program to ensure
	  • Use as a real-time tool available to inform prescribing practices
	  • Use as a data analytic tool

Coordinated Approach	• Ensuring a coordinated approach exists among entities to investigate & prosecute • Collaboration among stakeholders
Education	• Educational opportunities for providers • Guidelines on appropriate prescribing patterns
Proper Disposal	• Ensure proper disposal of prescription drugs through public education

Source: National Governors Association, Issue Brief: Six Strategies for Reducing Prescription Drug Abuse.

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Eligibility Determination Changes

- Asset tests
  - Will not be allowed in 2014 for non ABD populations
- Reduce or eliminate outreach activities
- Open Enrollment Periods for optional populations
- Require reporting of changes
  - WI- 10 days
  - Continuous eligibility

Mid-Term Strategy: Eligibility Changes

Current optional coverage groups may be reviewed for elimination effective 1/1/14 with the expiration of the ACA MOE. Additionally, coverage groups should be reviewed to prevent duplication of coverage options with groups newly eligible for premium tax credits (APTC).

Optional Category	Special Considerations
Residents of Institutions for Mental Disease (Under 21 & Over 65)	• Children's MOE extends through 2019
Recipients of State Supplement	• N/A
State Adoption Assistance	• Children's MOE extends through 2019
100% FPL for Aged & Disabled	• Without a Medicaid expansion to 138% FPL, these currently eligible individuals would experience a gap in coverage.
Working Disabled	• State can set asset limit; if elimination of entire group not desired, can impose stricter asset limit • Could implement premium increases
HIV/AIDS Waiver & HCBS Waiver	• N/A
Breast & Cervical Cancer	• Potential duplication with APTC; however, without Medicaid expansion, gap in coverage for individuals <100% FPL

Mid-Term Strategy: Eligibility Changes

Optional Category	Special Considerations
Medically Needy	• Non-duals become eligible for APTC • States operating medically needy program required to provide for children & pregnant women. Children's MOE extends through 2019; therefore State required to continue operating for both pregnant women & children • Could examine reducing eligibility period from 6 mos to monthly or quarterly • Could consider modifying what incurred medical expenses are considered for determination of spend-down eligibility

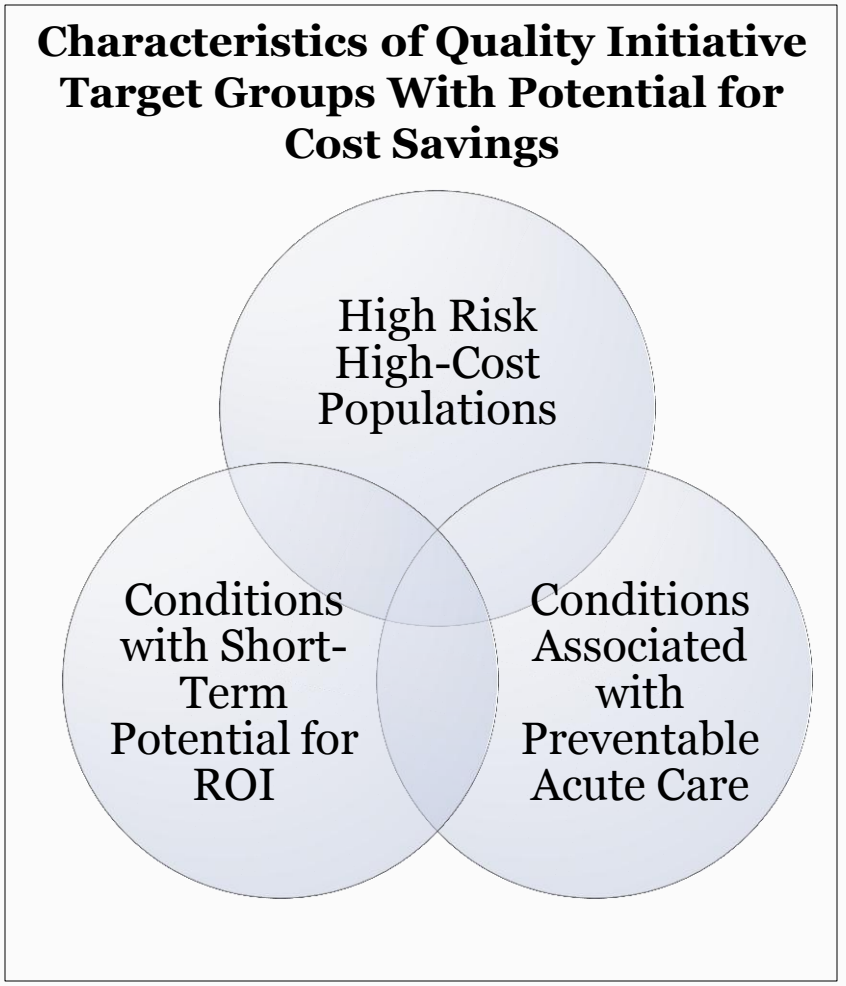
Pregnant Women	• Currently covered to 200% FPL
	• Duplication of coverage with APTC
	• Effective 1/1/14, State can lower income threshold to higher of:
	  • 133% FPL – or –
	  • Income standard up to 185% FPL in effect 12/19/89 or authorizing legislation as of 7/1/89

300% SSI for Nursing Home	• Maine is one of only 11 states to grant eligibility to individuals with equity interest in primary residence that exceeds federal requirement of $500K (set at $750k)

Mid-Term Strategy: Quality Initiatives

Center for Healthcare Strategies: *Business Case for Quality Initiative*

- Savings were found among:
  - Complex case management program for adults with multiple co-morbidities
  - Case management for children with high risk asthma
  - Outreach program for high-risk pregnant women
  - Care management program for adults with disabilities



Source: CHCS, Demonstrating the Business Case for Quality in Medicaid: Challenges & Opportunities, 2008.

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Quality Initiatives: State Example

- Indiana Notification of Pregnancy Program
  - Goal: To improve birth outcomes by identifying high risk pregnant women
  - Universal assessment form developed for Medicaid eligible pregnant women
    - Providers receive $60 for completion
    - The member is risk stratified & data is sent to her MCO
    - The MCO provides individualized care coordination based on risk assessment

Mid-Term Strategy: Program Integrity

- Strategies for enhanced fraud, abuse, and waste controls include:
  - Improved communication and collaboration between departmental control units and the Attorney General's Medicaid Fraud Unit*
  - Determination of the necessity of a financial and performance audit of the Medicaid program
  - Increased recovery efforts
    - From 2010-2012 Maine Medicaid Fraud Recovery Unit recovered $40M, increasing that effort a modest 5% could garner an additional $2M in recovered funds

* Maine is currently working on this.

Source http://bangordailynews.com/2012/09/05/health/drug-companies-health-care-providers-cost-state-millions-in-mainecare-fraud/

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Mid-Term Strategy: Program Integrity

- Maine should consider and follow up on recent recommendations (2009) provided by the Office of Program Evaluation & Government Accountability pertaining to:
  - The drivers of high administrative costs in MaineCare's children's outpatient mental health services
  - The development of stronger measures to ensure the prevention and detection of excessive, unnecessary and inappropriate claims

Source: Office of Program Evaluation and Governmental Accountability at http://www.maine.gov/legis/opega/Reports.html & A performance Audit of Fraud, Waste and Abuse Controls in Utah's Medicaid Programhttp://le.utah.gov/audit/09_12rpt.pdf

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Mid-Term Strategy: Program Integrity

- Over 20% of health care expenditures have been attributed to waste[1]
- Iowa implemented program integrity contract & reported $52M in savings over 2 years
  - FY 2011: $23M in savings
  - FY 2012: $30M in savings

Iowa's Program Integrity Initiative:
Savings attributed to claims analysis

Credit Balance Reviews	• $6.5M recovered annually • Review of repayments due upon TPL payment*
Billing Errors & Upcoding	• Focus on paper claims • Errors such as misplaced decimals • Providers claiming reimbursement for more expensive service than delivered
Dental Specific Issues	• Claims for services provided on teeth previously extracted

* Maine is currently doing.

[1]Berwick, D. and Hackbarth, A. Eliminating Waste in US Health Care. *JAMA. April 11, 2012.*

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Mid-Term Strategy: Managing Long-Term Care

- In addition to long-term strategies surrounding LTC that States are using to transform the delivery of care, more immediate strategies being utilized by States include:
  - Changing institutional reimbursement, freezing or lowering payments
    - Reductions in payments for bed-holds
    - Making nursing home level of care more strict
  - Long-Term Care Partnership Programs
    - To increase the percentage of LTC spending from private policies
    - Individuals who purchase LTC Insurance do not have to exhaust their assets to qualify
  - Implementing Affordable Care Act provisions targeted at shifting long-term care to community settings:
    - State Balancing Incentives Program
    - Community First Choice Option
    - Money Follows the Person Rebalancing Demonstration*

* Maine is currently working on this strategy.

Source: Kaiser Foundation, Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal & Cost-Sharing Policies in Medicaid & CHIP, 2011 – 2012, January 2012.

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Mid-Term Strategy: Reimbursement Reforms

- Potentially Preventable Events
  - Maryland expanded the hospital acquired conditions list for which reimbursement is barred beyond those required by CMS
  - Explore expanding potentially preventable to readmissions as well
  - C-Section Reimbursement

Source: Center for Health Care Strategies, Payment Reform: Creating a Sustainable Future for Medicaid, May 2010.

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Mid-Term Strategy: Revenue Enhancement

- Implementing Provider Taxes:
  - The Illinois Legislature has passed a bill to levy a provider tax through a five-year hospital assessment program. The Legislature approved a plan to borrow $510 million from special state funds to initiate the program; the assessment is expected to generate $4.5 billion in payments to hospitals and the State.
  - Ohio lawmakers approved the state budget with a provision for a hospital corporate franchise fee tax of 1.27 percent of total hospital operating costs.
  - New York is increasing taxes on health insurers to help fund graduate medical education and other programs.
  - Rhode Island has enacted a plan to issue a new premium tax on not-for-profit health care centers.
  - Wisconsin plans to implement a 1.4 percent tax on hospitals' gross patient revenues to draw additional Federal funding. The State will return most of the money to the hospitals and use some of the revenues to expand health care coverage to low-income, childless adults.
  - Indiana approved a temporary hospital assessment fee which was used to leverage federal funds to increase reimbursement to hospitals and also directed to the general fund.
  - Federal scrutiny of provider assessments

Sources: Medicaid Watch: State Medicaid Cost Containment Strategies

Long-Term Strategy: Value Based Purchasing

- MaineCare has been working to strategically implement a variety of value based purchasing initiatives
- Value based purchasing is a strategy used by employers, and increasingly various states and the federal government, to use their market power as a force to promote quality and value of health care services.
- The overarching goal of VBP is to build a health system based on value with a clear return on every dollar spent.
- Key Elements of value based purchasing:
  - Measuring and reporting comparative performance
  - Paying providers differentially based on performance
  - Designing health benefit strategies and incentives to encourage individuals to select high value services and providers and better manage their health care

Source: What is Value Based Purchasing? http://www.nbch.org/index.asp?bid=529&RequestBinary=True

Long-Term Strategy: Value Based Purchasing

- In January 2012 HHS announced Medicaid and CHIP (MAC) Learning Collaborative. Including the **Value Based Purchasing Learning Collaborative**. The collaborative will be rolled out in two phases.
- Phase one:
  - Ways to improve care and lower costs in non-risk based arrangements (e.g., primary care case management, fee for service)
  - Develop payment policies
  - Develop integrated care models
  - Develop quality measurement policies
  - Develop beneficiary protections
- Phase two:
  - Six to eight states dominated by managed care contracts will be selected to help states be more aggressive purchasers of care and design the next generation of MCO contracting.
- States will be selected to interact with peers and subject matter experts in a series of meetings, webinars and conference calls. Products generated by the collaborative, including technical tools and state resources will be disseminated to participating states.
- HHS participation and promotion of VBP lends it legitimacy and provides states with incentive to explore VBP options
- **Maine has been selected and is participating in the Value Based Purchasing MAC Collaborative**
  - The goal of Maine's participation is to buy better value by linking quality, payment reform, and integrated care models

Source: Medicaid and CHIP learning Collaborative at http://www.chcs.org/usr_doc/VBP_LC_Overview_Final.pdf

Purchasing Strategies

- Managed Care:
  - Predictable costs
  - Need quality measures
  - Degree of integration: mental health, LTSS, HCBS
- Health Homes
  - FFS with Bonus or Shared Savings/Patient-Centered Medicaid Home (PCMH)
  - New ACA initiative with enhanced funding
  - States can pay for care coordination, case management, health promotion, family support services, community referrals
  - Coordinate primary care, mental health, and LTSS

Accountable Care Organizations (ACOs)

- Provider risk sharing, full capitated, full range of services
- Reward providers for keeping patients healthy and out of hospitals
- Align incentives across providers
- Coordination across full spectrum of services
- Proivder investment; care coordination, HIT,
- How are payments divided amongst providers?

Payment Reform

- Bundled Payments
  - Flat fee
    - Surgery and 90 days follow up care
  - Paying for an episode of care, vs. FFS
  - Used by Medicare for hospital reimbursement
    - 50% of Medicare inpatient
    - 20% Medicaid inpatient
  - Maternity, pediatrics, primary care, LTSS
  - Similar to MCO capitation payments- wider range of services can be offered
- Multi Payor Approach

Bundled Payments

Bundled Payments & Episodes of Care:

- Covers all services associated with an episode of care
  - Ex: Inpatient hospitalization & post-discharge
- Payments combined for hospitals & physicians
- Shifts reimbursement away from rewarding quantity under fee-for-service arrangements

Research Findings on the Potential Savings Associated with Bundled Payments

Medicare Heart Bypass Center Demo.	• Saved 10% of projected spending • $42.3M
Geisinger Proven Care	• Decreased hospital costs 5%

Source: Center for Health Care Strategies, Payment Reform: Creating a Sustainable Future for Medicaid, May 2010.

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PCCM as Integrated Care Entity: State Examples

Community Care of North Carolina

- 2010: Began providing enhanced PMPM payment to existing PCCM program to support integration
- Payments used to hire a psychiatrist and behavioral health coordinator in each of the State's 14 networks
- Behavioral health flags also added to existing electronic care management tool to help identify members with needs

Vermont Blueprint for Health

- Part of Vermont's statewide multi-payer initiative to develop patient-centered medical homes
- PCPs are paid a PMPM fee based on their NCQA score as a Physician Practice Connections-Patient-Centered Medical Home
- Community Health Teams provide community-based care management & population management
- Goal is to increase the capacity of PCPs to treat mild & moderate mental health issues & collaborate with specialists on more complex cases

Source: Integrated Care Resource Center, State Options for Integrating Physical & Behavioral Health Care, October 2011.

Long-Term Strategy: Health Information Technology*

- Health Information Technology is an important complement to medical home models & other quality initiatives
  - Allows for better coordination of care
  - Potential for reduction in duplication of services
  - Improved data collection
- Additional funding made available to States through ARRA
  - Payment incentives for implementation of electronic health records
  - Grants to develop health information exchanges (HIE)

State HIT Initiatives

AL	• Online data sharing platform • Incorporates chronic disease management & EHRs
PA	• Common disease registry
AR	• Enhancing HIE to allow providers to better share patient data • Will measure provider performance across payers to provide aggregated feedback

* Maine is currently doing.

Source: Kaiser Family Foundation, Innovative Medicaid Initiatives to Improve Service Delivery & Quality of Care, September 2011

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Long-Term Strategy: Managing Duals

- Duals are among the nation's sickest and costliest Medicaid enrollees
- Care and reimbursement between Medicaid & Medicare is typically poorly coordinated
- Better integrated care represents potential cost-savings & improved outcomes
- Special Needs Plans (SNPs)
  - Effective 2013, all new SNPs that enroll duals must contract with State Medicaid agency

State Options for Contracting with SNPs

Contracting Method	Overview
MIPPA Minimum Requirement Agreement	All that is shared is ability to verify Medicaid eligibility & Dual SNP enrollment
Medicare Cost-Share Only	Verify eligibility & capitation paid to SNP for cost-sharing paid by Medicaid
Medicare Cost-Share & Medicaid Wraparound	SNPs provide Medicaid services not covered or partially covered by Medicare
Medicaid Medical & Long-Term Supports & Services	Fully integrated care for duals

Source: CHCS, Developing an Integrated Care Program for Dual Eligibles Using Special Needs Plans, January 2011

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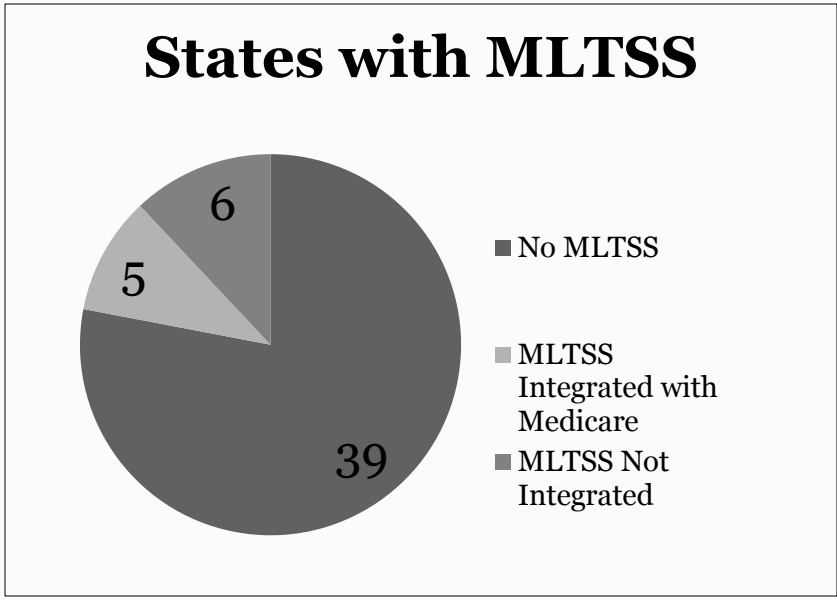
Long-Term Strategy: Managing Long-Term Care

- In addition to MLTSS SNPs, States have designed MLTSS programs which are not integrated with Medicare
- Program design among the states varies
  - All put MCOs at risk for the community-based long-term services & supports but MCO risk for other services varies
- States use of these programs is limited, so long-term cost-effectiveness studies are in their infancy & inconclusive
  - Proponents argue costs are predictable & services delivered in cost-effective manner
  - Others caution that short-term savings may not be achieved due to scope of covered services, MCO rates & other program costs



Source: Kaiser Foundation, Examining Medicaid Managed Long-Term Service & Support Programs, October 2011 & UnitedHealth Center for Health Reform & Modernization, Coverage for Consumers, Savings for States: Options for Modernizing Medicaid Working Paper #3, April 2010.

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Managing Long-Term Care Outcomes

Texas STAR+PLUS SNP - Integrated with Medicare	
Reduction in Avoidable Inpatient Care	22%
Reduction in acute outpatient care	15%
Reduction in ER visits	38%
Reduction in LTC	10%
Savings relative to FFS	8% (in one county)

Florida Nursing Home Diversion Program Not integrated with Medicare		
Likelihood of nursing home admission	FFS	MLTSS
	26%	12%
Likelihood of leaving nursing home & transitioning to community setting	4x more likely than FFS	
Savings attributed to nursing home avoidance	$10-$15k per member/year	

Source: [1]UnitedHealth Center for Health Reform & Modernization, Coverage for Consumers, Savings for States: Options for Modernizing Medicaid Working Paper #3, April 2010.

Long-Term Strategy: Managing High Cost Enrollees - Mental Health Strategies

- 28% of MaineCare expenditures are attributed to individuals with mental health conditions
- Nationally, coordination of care across physical and behavioral health has been lacking
  - Resulting in reduced quality outcomes & higher costs
- Opportunities to increase behavioral & physical health coordination presents the potential to improve clinical outcomes & reduce costs

Source: Integrated Care Resource Center, State Options for Integrating Physical & Behavioral Health Care, October 2011.

PCCM Program as Integrated Care Entity

Different models are available to integrate primary & behavioral health care in a PCCM model:

- Population focused care management
  - Behavioral health care manager receives referrals from primary care physician
  - Shared treatment plans & medical records across both physical health & behavioral health
- Primary Care Behavioral Health Model
  - Behavioral health staff provides care alongside primary care physicians
  - Care is provided promptly upon identification of needs
- Blended model
  - Includes both embedded care managers & behavioral health staff working alongside primary care providers
  - Department of Veterans Affairs is currently assessing

Source: http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

Model Components of a Physical/Behavioral Health Integration Strategy

System-Level

- Financial incentives aligned across physical & behavioral health
- Multidisciplinary care coordination teams
- Competent provider networks
- Real-time information & data sharing available to all members of the care team
- Mechanisms to assess & reward quality care

Point of Service

- Comprehensive screening for physical & behavioral health
- Engaging the enrollee
- Collaborative care plan development inclusive of enrollee, caregivers & providers
- Care coordination & enrollee support in navigating the system

Source: Integrated Care Resource Center, State Options for Integrating Physical & Behavioral Health Care, October 2011.

Physical & Behavioral Health Integration Models

MCO as Integrated Care Entity	• Both physical & behavioral health are included in State's MCO contracts • Contracts are either with traditional MCOs serving all Medicaid enrollees or through specialized MCOs that enroll only individuals with serious behavioral health issues
PCCM Program as Integrated Care Entity	• State contracts directly with provider or through a PCCM subcontractor
Behavioral Health Organization as Integrated Care Entity	• State contracts with Behavioral Health Organization to provide both physical & behavioral health for individuals with serious mental health needs
MCO/PCCM & Behavioral Health Organization Partnership	• Separation between physical & behavioral health is maintained • Behavioral health is carved-out to a BHO • Payment across physical and behavioral health is better aligned to encourage enhanced coordination

Source: Integrated Care Resource Center, State Options for Integrating Physical & Behavioral Health Care, October 2011.

BHO as Integrated Care Entity: State Example

Arizona

- Awarded a planning grant to explore a Regional Behavioral Health Authority (RBHA) model for individuals with Serious Mental Illness (SMI)
- RBHA model called "Recovery through Whole Health"
- Utilizes Health Homes to coordinate & integrate behavioral & physical healthcare for Medicaid recipients with SMI
- Exploring contracting with 1 or more at risk MCO to serve as the RBHA as of 10/1/13

Source: http://www.azdhs.gov/diro/integrated/rbha/index.htm & Integrated Care Resource Center, State Options for Integrating Physical & Behavioral Health Care, October 2011.

MCO/PCCM & BHO Partnership Facilitated by Financial Alignment: State Example

Pennsylvania SMI Innovations Project

- Capitated behavioral health carve-out
- Urban & suburban areas also have capitated system for physical health
- Launched 2 year pilot initiative to better integrate care for individuals with serious mental illness
- MCOs, BHOs and county behavioral health offices & providers partnered together in 2 regions
- Shared incentive pool tied to performance on process & outcome measures

Process Measures

- Joint risk stratification
- Integrated care plan creation
- Real-time hospital notification
- Management of antipsychotic medications

Outcome Measures

- Reduced hospital admissions
- Reduced ER visits

Requirements to Receive Incentives

- Identify members who could benefit from care management
- Develop real-time data exchange
- Implement effective interventions for improved care coordination

Source: Integrated Care Resource Center, State Options for Integrating Physical & Behavioral Health Care, October 2011.

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Pennsylvania SMI Innovations: An Overview of the Pilot Models

HealthChoices HealthConnections

- Community-based model
- Behavioral health provider agencies were established as the medical home
- Navigators employed by the behavioral health organization engaged providers & members to share information & develop care plans
- Monthly updated member profiles detailing health status, pharmacy utilization, hospital use & case management updates were made available to all providers

Connected Care

- Plan-based model
- Care coordination provided by MCO for members with frequent ER or hospital use
- Contact was primarily telephonic
- Subset of members received onsite nurse care management in primary care office
- MCOs facilitated multidisciplinary information sharing

Source: CHCS, Early Lessons from Pennsylvania's SMI Innovations Project for Integrating Physical & Behavioral Health in Medicaid, May 2012.

Pennsylvania SMI Innovations: An Overview of the Outcomes

- Both approaches reduced the rate of ER visits & hospital admissions in year two of the pilot
- Lessons learned
  - Overall State commitment & local ownership critical
  - Considerable time necessary to devote to understanding & developing protocols on privacy issues & data sharing
  - Nurses were a critical component of the multidisciplinary care teams
  - Strategies for enrollee engagement need to be flexible & modified as needed
  - Provider relationships are critical and development is resource intensive
  - Integrated health profiles were useful in sharing pertinent information across delivery systems

Source: CHCS, Early Lessons from Pennsylvania's SMI Innovations Project for Integrating Physical & Behavioral Health in Medicaid, May 2012.

Long-Term Strategy: Managing High Cost Enrollees-Individuals with Developmental Disabilities

- There are 61,500 people with disabilities covered by Medicaid in Maine. Maine spends roughly $14,062 on Each Medicaid Recipient.
- 18% of all people covered by Medicaid in Maine have a disability, while the national percentage is 15%.
- The state spends 45% of all the money it spends on Medicaid on services for people with disabilities, while the national percentage of Medicaid spending on these services is 42%.

Sources: Kaiser Family Foundation Medicaid Fact Sheet

Long-Term Strategy: Managing High Cost Enrollees-Individuals with Developmental Disabilities

- Benefit Modifications
  - Wisconsin curbed dental benefits for the developmentally disabled as part of a $447M Medicaid reduction package
- Broad cost containment strategies have not been targeted at the disabled population
- Few state initiatives are targeted at top expenditures for disabled persons, those that do exist are modest

Sources: Wisconsin Disability Budget Proposals at http://www.dawninfo.org/advocacy/budget.cfm and the U.S. Office of the Inspector General

Overview: A Review of State-Specific Strategies

- Seven states were reviewed to identify recent cost-cutting strategies, innovative solutions & budget impacts
  - Maryland
  - Iowa
  - Wisconsin
  - Arizona
  - Arkansas
  - Minnesota
  - Idaho

Overview: Maryland Cost Cutting Strategies

- FY 2012: Legislature tasked Maryland Medicaid with generating $20M budget savings without specific mandates on how to achieve savings
- Received 190 recommendations through a public comment process
- 7 strategies adopted

2012 Cost Containment Strategy	Details	Estimated Savings
Paid FY 2012 bills in FY 2011	Obtained enhanced ARRA match rate	$8.15M
Recovery from MCOs related to medical-loss ratio		$5.32M
Reduce MCO capitation rates by ½%		$3.75M
Transfer eligible children from Title XIX to Title XXI	Allowed State to obtain enhanced Title XXI FMAP	$0.38M
Accelerate eligibility process for certain individuals in nursing homes	When Medicaid enrollees entered nursing facility, a new financial eligibility process was triggered. By deeming individual financially eligible, individuals could be more quickly moved to HCBS if eligible.	$0.60M
Reduce rates for DME, DMS & oxygen	Review revealed lower rates in neighboring states.	$0.50M
Recover settlement funds from nursing facilities under a lawsuit	State specific lawsuit.	$1.30M
TOTAL		**$20M**

FY 2013 Maryland Cost Cutting Strategies

2013 Cost Containment Strategy	Details	Estimated Savings
MCO 1% capitation rate reduction		$15.9M
Accelerate MCO MLR recovery to 100%	Changes the recovery rate for when an MCO does not meet the MLR to 100% regardless of performance in previous years.	$3M
Reduce inpatient hospital benefit package for medically needy		$36M
Implement tiered outpatient rates	Tiered rates under which low-cost outpatient services have a lower rate than a higher cost service. On average across all services, the rate to equal those previously in effect.	$30M
Implement DSH pool	Shifting greater % of funds to DSH pool (previously 50% of DSH paid through statewide pool).	$9.1M
Continue rate freeze for certain hospitals		$1.5M
Eliminate communicable disease care payments	Add-ons had been paid to healthcare providers managing communicable diseases. Costs found not to justify the add-on.	$5.8M
Reduce DME payments to 90% of Medicare		$1M
Implement In Home Supports Assurance Program	Procured vendor to verify when provider arrives & leaves home.	$2.8M
Move end-stage renal disease from state-funded program to Medicaid	Maximizes federal match.	$1M
Identify dual eligible's and apply for Medicare	Maximizes TPL collections.	$1M
Review denied Medicare services which should not be billed to Medicaid		$1M
Move MCHIP eligible children from Medicaid	Enhanced Title XXI funds received	$1.5M
Compares SSI recipients with federal approved lists	Removal of individuals no longer eligible for SSI from Medicaid rolls.	$3.6M
Pharmacy initiatives on antipsychotic medications	Improve use of generics, dose optimization & implement peer to peer UR	$5M
Increase provider assessment rates	Nursing home from 5.5% to 6% & implemented for Medical Day Care at 5.5%	$8.9M
TOTAL		**$127.1M**

Maryland Antipsychotic Medication Initiatives

- Child Targeted Interventions:
  - Launched the Peer Review Program for Mental Health Drugs in October 2011
    - Targeted the use of antipsychotics in children under age 5
    - Expanded the program in July 2012 to children up to age 10
  - Claims for antipsychotic medications for children younger than the FDA approved age require prior authorization
  - Renewed authorization required after 3 months
- PA required for Tier 2 & Non-Preferred Antipsychotic Medications for Patients Age 10 & Older
  - Criteria for immediate approval:
    - Medication was initiated in an inpatient unit/acute care setting
    - All preferred antipsychotics are medically contraindicated
  - All other requests evaluated based on:
    - The patient has had an adequate trial (at least 6 weeks at recommended dose)
    - The patient has FDA indicated diagnosis
    - The requested medication complies with the FDA package dosage and frequency

Source: http://www.marylandmedicaidpharmacyinformation.com/
http://mmcp.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx

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Maryland Long-Term Strategic Initiatives

- At direction of State Legislature, Medicaid Advisory Committee undertook review of cost-drivers in Medicaid
- Developed recommendations for reducing expenditures
- The strategic initiatives identified include[1]:
  - "Rebalancing long-term care
  - Changing the way services are delivered by analyzing upward and downward substitution of higher cost services
  - Implementing medical homes
  - Improving efficiency and quality, while avoiding duplication of services, through Electronic Health Records
  - Ensuring that Medicaid remains the payer of last resort"

[1] Source: Report on Medicaid Financing & Cost Drivers retrieved at http://mmcp.dhmh.maryland.gov/SitePages/2012-attachments.aspx#jan

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Overview: Iowa Cost Cutting Strategies

FY 2013 Cost Containment Strategy	Details	Projected Savings
Increased TPL Collections*		$1.6M
Medicare Crossover Claims*	Cap the payments for Medicare crossover claims to no more than Medicaid payment	$9.2M
Primary Care Health Home*	Implementation of new health homes for individuals with multiple chronic conditions. 90% FMAP for 2 years.	$4.9M
Pharmacy Average Acquisition Cost (Individual State analysis required to determine impact based on current pricing)	Convert reimbursement methodology for prescription drugs.	$1.9M
Physician Prescription Drug Reimbursement	Aligning prescription drug reimbursement by physicians with drugs dispensed from pharmacy.	$85K
Medicare Part B disallowance	Recover claims that should have been paid by Medicare.	$97.5K
Estate Recovery	Iowa Public Employees' Retirement System to begin notifying Medicaid of recipient death & recovery to occur prior to disbursement to beneficiary	$780K
Hospital readmission within 7 days*	When readmitted within 7 days, payment consolidated to 1 stay	$253.5K
Applying Medicaid edits on claims paid to Medicare		$1M
Balancing Incentive Program	Enhanced match rate of 2% for non-institutional long term services and supports.	$17.8M
TOTAL		**$37.6M**

* Maine is currently doing.

Source: June 2012 Iowa Monthly Medicaid Forecast, https://www.legis.iowa.gov/DOCS/lsaReports/medicaid/2012/June.pdf & https://www.legis.iowa.gov/DOCS/LSA/SC_MaterialsDist/2012/SDJRB047.PDF

Overview: Wisconsin Cost Cutting Strategies

- Wisconsin faced with a $3.6B budget deficit
- CMS -approved Medicaid changes estimated to save the state $28.1M annually
  - Cost Sharing:
    - Added or increased monthly premiums for most non-pregnant adults with incomes above 133% FPL
  - Eligibility Changes:
    - Parent & caretaker enrollees who have access to an affordable employer-sponsored health insurance plan will no longer qualify for Medicaid
  - Stronger Enrollee Reporting Requirements:
    - Enrollees must report income changes within ten days

Source: Wisconsin Department of Health Services at http://www.dhs.wisconsin.gov/news/PressReleases/2012/042712-bc.htm

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2011-13 Wisconsin Long Term Proposed Efficiency Items

Cost Containment Strategy	Estimated Savings
Alternative Bench Mark Plan	TBD
Maximum Drug Rebate Collections*	$3M
Pharmacy Collaborative Participation	$1M
Asset Test Enhancement*	$1M
Eligibility Determination Integrity	TBD
Enhanced Third Party Liability Participation*	$3.6M
Federal Claiming Enhancements	$27M
Implementation of EAPG Grouping System For Outpatient Hospital	$1..6M
Increased Auditing and Audit Enhancements*	$11.6
Managed Care/FFS Payment Review	$2M
Pay for Performance for HMOs	$0.7M
Pay for Performance for Hospitals*	$5M
Physician Rate Change for Certain Services Provided in a Hospital	$0.7M
Reimbursement Modification for Consultation Services	$1.2M
Recovery Audit Contractors*	$3.0M
Targeted Clinical Pharmacy Utilization	TBD
Wisconsin Medicaid Cost Reporting Reform	$15M
Children in Foster Care Medical Home Initiative	TBD
Long Term Care Pilot Program- Virtual PACE	TBD
Transportation Manager	$3.4M
TOTAL	**$79.7M**

* Maine is currently doing or in process of implementing.

Source: Dennis G Smith Secretary of the Wisconsin Department of Health Services ttp://www.dhs.wisconsin.gov/mareform/JFC06.29.12.pdf

Overview: Arizona Cost Cutting Strategies

- Arizona 2012 projected budget shortfall of $825M
- In October 2011 CMS approved reimbursement changes that would result in $95M in savings.
  - Reimbursement Rate Reduction:
    - 5% rate reduction to Medicaid providers
  - Eligibility Changes:
    - Enrollment cap for child-less adults
    - Elimination of the spend down category which covered 6,000 people whose medical bills had reduced their income to 40% of FPL
  - Reductions In Services: (pending CMS approval)
    - 25 day inpatient hospital limit for adults 21 years or older within a 12 month period of time. Limit does not apply to:
      - Children aged 20 and under, days in certain burn units, days that are part of transplant stay, days in the hospital for behavioral reasons

Sources: Xcenda Archives CMS Approves Second 5% Decrease In Arizona's Medicaid Payments to Providers; Arizona Department of Economic Security at https://www.azdes.gov/main.aspx?menu=96&id=5698

Arizona Long Term Reform Plan

Containment Strategy	Projected Savings
Eliminate enrollment of childless adults	$190M
Eliminate spend down program	$70M
Eliminate enrollment of parents earning 75% of FPL	$17M
Eliminate Federal Emergency Programs for non-qualified aliens	$20M
Require 6-month redetermination of eligibility for current enrollees	$15M
Expand mandatory co-payments for parents	$2.7M
Expand mandatory co-payments for children	TBD
Institute a “no show” penalty for missed appointments	TBD
Impose new benefit limits	$40M
Eliminate non-emergency transportation services	$1M
Modify reimbursement rates	$95M
State reimbursement of what should have been Medicare charge	$40M
Avoid Indian Health Service cost shift	TBD
TOTAL	**$490.7M**

Source: State of Arizona Proposed Medicaid Reform Plan at http://azgovernor.gov/dms/upload/PR_031511_AHCCCSSummary.pdf

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Overview: Arkansas Cost Cutting Strategies

- Facing a $60-80M Medicaid deficit in 2012-2013 and $200M in 2013-14
- Arkansas has developed the "**Arkansas Health Payment Improvement Initiative,**" a partnership between Medicaid, Medicare, and private health insurers.
- Key Features of the Initiative include:
  - "Partnerships" of providers
  - Bundled payments for episodes of care
  - Health homes
  - All-payer claims database/transparency
  - Health information Technology
  - Wellness and prevention
- Reform will focus on nine priority areas:
  - Pregnancy
  - Prevention
  - Mental health
  - Diabetes
  - Back Pain
  - Cardiovascular disease
  - Ambulatory upper repertory tract infections
  - Developmental disabilities
  - Long-term care
- Plan details are still being negotiated between providers & state officials, roll out has been moved to July 1, 2013
- The Arkansas Department of Health Services projects the initiative will save the state $15M in 2014

Source: The Barriers to Arkansas' Healthcare Reform and Possible Ways to Overcome Them at http://www.mitchellblackstock.com/PDF/Arkansas_Healthcare_Reform_Article_Pt_1.pdf ; http://arkansasnews.com/sections/news/arkansas/officials-ask-aarp-lobby-medicaid-expansion-payment-reform.html

Overview: Minnesota Cost Cutting Strategies

- Minnesota 2012 projected budget deficit of $5.8B for the 2012-2013 biennium
- Minnesota has taken the following cost containment actions:
  - Provider Payments:
    - 1.5% rate reduction in 2011
  - Tighter Pharmacy Controls:
    - Will deny non-citizens prescriptions
  - Modified Co-Pays:
    - Raised Co-Pays for childless non-disabled adults below 250% of FPL

Sources: Medicaid Watch: State Medicaid and Health Cuts & Expansions at http://www.adapadvocacyassociation.org/pdf/Medicaid_Watch.pdf

Overview: Minnesota Long-term Strategic Initiatives

- The 2011 Minnesota Legislature directed DHS to reform Medicaid
- Minnesota DHS response is the Reform 2020 initiative
- First steps of Reform 2020 include:
  - 1115 waiver - Nursing Facility Level of Care
    - Permission to implement the 2009 level of care criteria
    - Federal matching funds for alternative care
    - Federal matching funds for expanded version of essential community supports . Proposes to serve:
      - MA ineligible seniors
      - Transition Group: Individuals of any age who were receiving LTC services under MA and lose eligibility for those services
  - Duals financial integration model application
  - Long Term Care Realignment waiver proposal:
    - Requests federal authority to implement the new nursing facility level of care criteria

Source: Minnesota Department of Human Services at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166654

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Overview: Idaho FY 2012 Budget Cuts

Change	Description of Change	Estimated State Savings
Eliminates inflation adjusted provider rate increases	Nursing homes, intermediate care facilities, personal care services, physicians and dentists will no longer receive inflation increases. Rate changes to be requested during annual budget process.	$4.7M
Pharmacy reimbursement	Implements Average Acquisition Cost methodology	$2M
Therapy reimbursement	Implements blended rates for individual & group developmental therapy	$1.1M
Rate reductions	Reduced to 90% of Medicare for non-primary care codes & therapy service	$1.8M
Service reductions	Caps therapy services at $1,870/yr, emergency dental only, limits annual chiropractic to 6/year; podiatry & optometry for chronically ill only, weekly limits on psychosocial rehab.	$5.2M
Changes to DD waiver	A budget is assigned to each person based on their assessed level of care	$2M
Increase the use of HCBS*	Implementing Money Follows the Person	$1.3M
Changes to cost-sharing	Implements new co-pays	TBD
National Correct Coding Initiative (NCCI)	Implements NCCI	$50K
Provider taxes	County hospital tax & intermediate care facility & changes to nursing home assessment process	$7.5M
Program Integrity	Expanded use of civil monetary penalties, increase staff & new data analysis	$1.1M

* Maine is currently working on implementing.

Source: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HB260%20-%20FAQs.pdf

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